DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 01-006

2. STATE: North Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 19, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR 440.100

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 7,000
b. FFY 2002 $ 14,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment to Page 4 of Attachment 3.1-A
(2 pages)
Attachment to Page 4 of Attachment 3.1-B
(2 pages)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment to Page 4 of Attachment 3.1-A
(2 pages)
Attachment to Page 4 of Attachment 3.1-B
(2 pages)

MAY 18 A 10:34

10. SUBJECT OF AMENDMENT:
Dental Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
David J. Zentner

14. TITLE:
Director, Medical Services

15. DATE SUBMITTED:
May 11, 2001

16. RETURN TO:
David J. Zentner
Director, Medical Services
ND Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
May 18, 2001

18. DATE APPROVED:
6/11/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
4/19/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: May 11, 2001

FORM HCFA-179 (07-92)

*Instructions on Back*

State: North Dakota

LIMITATIONS ON AMOUNT, DURATION AND SCOPE

10. Dental Services. The Department will not pay for the following dental services by indicated coding unless the department's dental consultant determines that a special circumstance exists that justifies authorizing payment for the service.

| | Procedure(s) | Code(s) |
|---|---|---|
| 1. | Certain Radiograph Procedures | 00250,00260,00277 – 00321, 00340, 00350 |
| 2. | Tests and Laboratory Examinations | 00415 – 00480 |
| 3. | Other Preventive Services | 01310 – 01330 |
| 4. | Gold Foil Restorations | 02410 – 02430 |
| 5. | Inlay/Onlay Restoration | 02510 - 02664 |
| 6. | Indirect Pulp Cap | 03120 |
| 7. | Root Canal Therapy for Teeth with 3 or 4 canals for recipients over age 18 | 03330 |
| 8. | Endodontic Therapy | 03331 – 03333 |
| 9. | Other Endodontic Procedures | 03910, 03920, 03950, 03960 |
| 10. | Surgical Services including usual Postoperative Services | 04210 – 04274 |
| 11. | Adjunctive Periodontal Services and Other Periodontal Services | 04320, 04321, 04381, 04920 |
| 12. | Adjustments to Dentures when the Dentures were made by the same Dentist | 05410-05422 |
| 13. | Temporary Complete Dentures | 05810 - 05811 |
| 14. | Precision Attachments | 05862 – 05875 |
| 15. | Implant Procedures | 06010 – 06199 |

State: North Dakota

10. Dental Services (Continued)

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|---|---|---|
| 16. | Other Fixed Partial Denture Services | 06920, 06940 – 06971, 06976, 06980 |
| 17. | Tooth Transplantation Procedures | 07272 |

OTHER LIMITATIONS

1. Payment for single crowns on posterior teeth is limited to stainless steel crowns unless a dental condition exists that makes stainless steel crowns impracticable. Any exception must be approved through a special consideration approval by the department's dental consultant.

2. Payment for missing single teeth in the posterior portion of the mouth is not a covered service.

3. Payment for removal of third molars for non-symptomatic reasons is not a covered service.

4. Payment of sterile trays is not a covered service

5. Replacement of dentures (codes 05000 – 05899) is not a covered service within five years of the placement of the original or subsequent replacement dentures unless the change is prior approved by the dental consultant due to a change in the physical condition of a recipient that renders the present dentures unusable.

6. Reline/Rebase of dentures in an immediate/emergency situation is limited to one every six months.

7. Reline/Rebase of dentures for other situations is limited to one every 24 months.

8. Orthodontic services are not covered under the North Dakota Medicaid Program unless the services are provided in conjunction with, or in lieu of, oral maxillofacial surgical services and the orthodontic service is likely to correct or mitigate a congenital or acquired deformity associated with a significant functional impairment in drinking, eating, swallowing or speaking.

9. Replacement of lost or broken orthodontic appliances and splits is limited to no more than one replacement.

10. Dental services identified by the Medical Services Division as requiring prior approval and listed in the Dental Provider Manual will not be allowed for payment unless providers obtain prior authorization to perform the service.

State: North Dakota

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